ANDERSON EXHIBIT 26G

In my remarks today I would like to emphasize four points: First, in response to the OBRA 1990 manufacturers have dramatically increased the cost of pharmaceuticals for public hospitals. In 1991 alone these costs rose by more than $130 million to public hospitals.

Second, public hospitals, serving as they do the uninsured, the underinsured, cannot pass these additional costs on to the payers because many of these patients, as I said, do not have insurance and the taxpayers in Dallas County must absorb these costs.

Third, to cope with these increases our local hospital has had to restrict our formularies and the number and the volume of prescriptions that we provide to our patients.

This has affected the quality of health care our patients are to receive and they are the most vulnerable patients because they actually have no place else to go. This is the hospital of last resort.

Fourth, simply exempting the public hospitals from the best price provisions of OBRA 1990 will not even provide the relief that is desperately needed for our hospitals.

The last 2 years have demonstrated that the pharmaceutical manufacturers are in some cases willing and able to set drug prices, even the prices they charge public and teaching hospitals. A price roll back or at a minimum some sort of rebate is clearly required.

As other witnesses have demonstrated, the Medicaid Rebate Program established by OBRA 1990 has had a number of unintended and unforeseen consequences. The cause of these consequences is straightforward. OBRA 1990 creates incentives for drug manufacturers to close the gap between their average price and the best price.

The manufacturers did this not by lowering their average price, but by rather increasing their best price by reducing and in some cases eliminating the discounts offered to their best customers.

A 1991 study by NAPH supports these conclusions. That study found that pharmaceutical manufacturers responded to OBRA 1990 by substantially increasing the prices they charge public hospitals. Based upon a survey of 45 public hospitals and hospital systems, NAPH researchers found on the average the price increases that the manufacturers charged public hospitals rose 14 percent in the year immediately following the OBRA 1990, when it took effect.

As NAPH hospitals collectively spend more than $967 million a year each on pharmaceuticals, NAPH estimated that a reduction and elimination of the best price discounts cost these hospitals more than $130 million in 1991 alone.

I have included and passed out a very simple graph that shows what is happening to Parkland Hospital. In 1989 our cost of drugs at Parkland was $15.7 million. They increased as they had in the past about 3 to 5 percent, $17 million. Immediately following OBRA 1990 our drug costs went from $17 million to $24 million. That is almost a 30 percent increase in one hospital alone. We did not change the basic services they provide the patients. However, we did try, as I said earlier, to go back to try to find other ways to provide lower cost prescriptions to our drugs for our patients.

If we had not done that we estimate it would have cost us an additional $3 million. By trying to do that and trying to improve in-

ventories, we still were looking at a 30 percent increase. Now, as we go into 1993 we are projecting a budget of $31.7 million. That is about almost a 100 percent increase in 3 years.

One of the things that we have to do to pay for these drugs, we had built a nursery that came on line. The construction was completed 1½ years ago. We have been unable to open that nursery to take care of many of our patients in a higher quality setting because we just don't have the dollars. The dollars went into prescription drugs.

Mr. WAXMAN. Thank you. The rest of your testimony will be included in the record.

[Testimony resumes on p. 96.]

[The prepared statement of Mr. Day follows:]

N A P H

Testimony of

MacGregor Day
Executive Vice President and
Chief Operating Officer
Parkland Memorial Hospital, Dallas, Texas

before the

Subcommittee on Health and the Environment
of the
House Energy & Commerce Committee

July 31, 1992

Mr. Chairman, my name is Mac Day and I am Executive Vice President and Chief Operating Officer of Parkland Memorial Hospital in Dallas. Parkland is a 940-bed public teaching hospital which, I am proud to note, has been a leader in many specialized areas of health care, including trauma intensive care, burn treatment, and pediatric trauma. I am here today on behalf of Parkland, and on behalf of the National Association of Public Hospitals (NAPH). NAPH represents more than 100 major hospitals and hospital systems in metropolitan areas across the country. These hospitals serve the poor and near-poor in the Nation's cities; more than half of the people served by NAPH hospitals are either Medicaid recipients, or uninsured, or underinsured. This is why NAPH hospitals are often referred to as "safety net" hospitals.

In my remarks today, I would like to emphasize four points.

- First, in response to the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) manufacturers have dramatically increased the cost of pharmaceuticals for public hospitals--in 1991 alone, these costs rose by more than $130 million.
- Second, public hospitals, serving as they do the uninsured and the underinsured, cannot compensate for these dramatic cost increases by passing the costs onto other payors.
- Third, to cope with these increases, our hospitals have had to restrict their formularies--that is, the drugs regularly carried in their pharmacies--and this has affected the quality of health care received by the vulnerable populations served by public hospitals.
- Fourth, simply exempting the public hospitals from the "best-price" provisions of OBRA '90 will not provide the relief desperately needed by our hospitals. The last two years have demonstrated that pharmaceutical manufacturers are, in some cases, willing and able to set drug prices, even the prices they charge public and teaching hospitals. A price rollback--or, at minimum, some sort of rebate--is clearly required.

As you know, Mr. Chairman, pharmaceuticals have long been a substantial and problematic component of Medicaid program costs: currently, Medicaid spends more than $4 billion on prescription drugs. In OBRA '90, Congress rightly sought to establish some control over these expenditures. OBRA '90 required drug manufacturers to pay rebates to Medicaid programs; although the precise formulas are somewhat involved, the amount of the rebates are basically determined by the difference between the average price charged for the drug and the "best price" for the drug--that is, the lowest price paid by any purchaser (with some exceptions). The theory behind the bill was simple: whatever deal a drug manufacturer could offer its best customers, OBRA '90 required the manufacturer to offer Medicaid programs the same deal.

As other witnesses have demonstrated, this rebate program has had a number of unintended and deleterious consequences. The cause of these consequences is straightforward: OBRA '90 creates great incentives for drug manufacturers to close the gap between their "average price" and their "best price." The manufacturers did this not by lowering their "average price," but rather by increasing their "best price"--by reducing and, in some cases, eliminating the discounts offered to their "best" customers.

Study after study has documented this effect. A recent analysis by the Congressional Budget Office found that, in 1991 alone, manufacturers eliminated or reduced discounts on 57 percent of the drugs studied. A study by the Department of Veterans Affairs confirms and quantifies this finding. The VA estimated that OBRA '90 would increase drug costs for VA hospitals by at least $117 million annually.

A 1991 study by NAPH supports these conclusions. That study found that pharmaceutical manufacturers responded to OBRA '90 by substantially increasing the prices they charged public hospitals. Based on a survey of 45 public hospitals and hospital systems, NAPH researchers found that, on average, the prices manufacturers charged public hospitals rose 14 percent in the year after OBRA '90 took effect. As NAPH hospitals collectively spend more that $960 million each year on pharmaceuticals, NAPH estimated that the reduction and elimination of best-price discounts cost these hospitals *more than $130 million* in 1991. Table 1 summarizes the findings of that study.

A new study by New York University's Robert Wagner School of Public Service further documents the impact of OBRA '90 on the Nation's public hospitals. The study analyzed detailed data from five member hospitals and focused on the most widely used outpatient drugs. The NYU researchers found that, in the wake of OBRA '90, manufacturers promptly canceled discount contracts, terminated special-price practices, and raised the prices they charged public hospitals. I would direct the Committee's attention to some of the study's findings:

- the costs of the most common outpatient drugs increased sharply, with hospital costs for the drugs included in the study increasing by 22 to 62 percent with an average increase of 32 percent (see Tables 2-6);

- considering only the twenty-odd drugs included in the study, price increases following OBRA '90 cost these six hospitals almost $2 million;

- some of the most commonly used drugs experienced phenomenal price increases: for example, the price of the anti-coagulant Albuterol increased 88 percent, the price of Phenytoin, a common anti-epileptic, increased 200 percent, and the price of Warfarin, a frequently prescribed broncho-dilator, increased 4000 percent--all in a single year (see Table 7).

These increases far outpaced any increase in the manufacturers' costs or any background inflation. Historically, public hospitals have experienced annual increases in drug prices on the order of 5-9 percent. This suggests that at least half of the recent leap in drug prices is due to the pharmaceutical manufacturers' response to OBRA '90.

Although these price increases have affected many health care providers, the urban public hospitals are particularly vulnerable to such uncontrolled inflation. The reason for this is simple: these safety net hospitals cannot shift such cost increases onto other payors. On average, more than one-third of all public hospital patients are uninsured or underinsured. Add to that the fact that one-third of our patients are Medicaid recipients and you begin to understand why public hospitals are squeezed by the price hikes of the pharmaceutical manufacturers. In my hospital, Mr. Chairman, more than 73 percent of all care goes uncompensated by any payor. Thus while other hospitals can make up for pharmaceutical cost increases by spreading the costs to other patients, hospitals like Parkland do not have that luxury.

As a result, public hospitals have had to restrict their formularies, limiting the drugs available to their patients. This is ironic because one of the purposes of OBRA '90's Medicaid amendments was to eliminate restricted formularies at the state level and thereby enhance the quality of care received by Medicaid patients. This congressional intent is being thwarted by the pharmaceutical manufacturers: the manufacturers' price increases have forced public hospitals--which serve a very large number of Medicaid recipients--to restrict the drugs they are able to carry. This may be the most perverse unintended consequence of OBRA '90: while the law was designed to reduce Medicaid costs, it has severely burdened the hospitals that serve poor and near-poor populations, and diminished the quality of care received by those needy persons.

The fourth and final point I wish to emphasize, Mr. Chairman, is that exempting public hospitals from the best-price provisions of OBRA '90 will not provide the relief that those hospitals desperately need. The last two years have demonstrated that the pharmaceutical manufacturers are able to effectively set prices for many of the drugs they sell to public hospitals. Both the NAPH study and the NYU study demonstrate as much. Despite the fact that OBRA '90 only addressed the price of *outpatient drugs*, pharmaceutical manufacturers increased prices on *both inpatient and outpatient drugs*. Similarly, although OBRA '90 expressly exempted nominal-price products, the manufacturers quickly ended those special arrangements as well. For example, one public hospital that had received oral contraceptives from the

manufacturer for a nominal price of one cent per package suddenly found itself paying the "wholesale" price of $16 per package.

As these findings demonstrate, the fact that public hospitals purchase pharmaceuticals in substantial quantities does not guarantee reasonable prices for necessary drugs. There can be no assurances that exempting public hospitals from the best-price provisions of OBRA '90 will prevent pharmaceutical manufacturers from continuing to increase the drug costs of public hospitals--hospitals that serve as the Nation's health care safety net. Mr. Chairman, something more than an exemption--whether it is a rollback in prices (the most reasonable and sound response), or a rebate of some form--is necessary to protect both the fiscal integrity of safety-net hospitals and the quality of health care for the millions of citizens served by those hospitals.

The three bills under consideration offer different correctives for the manufacturers' response to OBRA. All of them, however, recognize that some providers of health care--such as public health clinics and community health centers--are particularly vulnerable to severe price increases by pharmaceutical manufacturers. As the two studies I have discussed today demonstrate, safety-net hospitals are likewise vulnerable to and suffering from these drastic price increases. We understand that Representative Wyden is now drafting an amendment that recognizes this fact and that extends the corrective legislation to safety-net hospitals. We commend his efforts. Parkland, and all of the other members of the National Association of Public Hospitals, hope that the Committee will also recognize this reality, and will provide these hospitals with relief from the recent and unconscionable increases in the price of pharmaceuticals.

Thank you for the opportunity to testify before you; I would be happy to answer any questions you might have at this time.

Table 1: NAPH PHARMACEUTICAL COST SURVEY, 1991

Projected Impact of Manufacturers' Response to OBRA '90 on NAPH Hospitals

Total Pharmacy Costs for NAPH Hospitals	$961,552,001
Average Cost Increase in Response to OBRA '90	14%
Projected Cost to NAPH Hospitals	$132,936,333

NAPH Pharmaceutical Survey Summary

Hospital	Pharmaceutical Costs (1990)	% Increase (1990–91)	Projected Cost Increase
Bexar County (San Antonio, TX) Hospital District	$14,000,000	14%	$1,960,000
Boston City Hospital	$5,075,265	25%	$1,268,816
Brackenridge Hospital (Austin, TX)	$3,500,000	17%	$595,000
DC General Hospital	$4,450,000	15%	$667,500
Earl K. Long Memorial Hospital (Baton Rouge, LA)	$1,500,000	15%	$225,000
Fairmont Hospital (San Leandro, CA)	$1,800,000	10%	$180,000
Grady Memorial Hospital (Atlanta, GA)	$18,235,975	10%	$1,823,598
Hennepin County (MN) Medical Center	$10,539,114	9%	$948,520
Highland General Hospital (Oakland, CA)	$3,750,000	25%	$937,500
LAC*Harbor UCLA Medical Center	$9,000,000	10%	$900,000
LAC*High Desert Hospital	$1,616,000	10%	$161,600
LAC*USC Medical Center	$29,000,000	10%	$2,900,000
Maricopa Medical Center (Phoenix, AZ)	$6,000,000	5%	$300,000
Memorial Medical Center (Savannah, GA)	$44,578,027	15%	$6,686,704
Merrithew Memorial Hospital & Clinics (Martinez, CA)	$4,100,000	10%	$410,000
Milwaukee County (WI) Medical Complex	$6,976,609	15%	$1,046,491
New York Health & Hospitals Corp. (16 facilities)	$120,000,000	20%	$24,000,000
Northwest Texas Hospitals	$3,775,102	15%	$566,265
Parkland Memorial Hospital (Dallas, TX)	$27,000,000	10%	$2,700,000
Pontiac General Hospital	$2,499,415	5%	$124,971
Regional Medical Center (Memphis, TN)	$10,517,687	20%	$2,103,537
R.E. Thomason General Hospital (El Paso, TX)	$6,153,000	15%	$922,950
San Francisco General Hospital	$12,809,965	10%	$1,280,997
San Mateo County (CA) General Hospital	$1,500,000	21%	$315,000
Santa Clara Valley (CA) Medical Center	$11,902,221	10%	$1,190,222
Truman Medical Center (Kansas City, MO)	$4,300,000	10%	$430,000
University Hospital at Brooklyn	$5,592,600	15%	$838,890
University of Cincinnati Medical Center	$11,185,257	10%	$1,118,526
UT Medical Branch (Galveston, TX)	$13,267,812	5%	$663,391
Westchester County (NY) Medical Center	$11,800,000	15%	$1,770,000
Totals	$427,014,049	14%	$59,035,478

TABLE 2: GRADY MEMORIAL HOSPITAL (Atlanta, GA)
PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 1990–1991	1990 Units Purchased	TOTAL COST 1990	TOTAL COST 1991	COST INCREASE 1990–1991
OXYCODONE/APAP TAB (100s)	DUPONT	$1.00	$43.00	4200%	750	$750	$32,250	$31,500
WARFARIN 5mg TAB (100s)	DUPONT	$2.00	$35.00	1650%	2500	$5,000	$87,500	$82,500
PHENYTOIN 100mg CAP (1000s)	PARKE DAVIS	$30.00	$90.00	200%	1000	$30,000	$90,000	$60,000
TERCONAZOLE VAGINAL CREAM	ORTHO	$4.10	$8.75	113%	25000	$102,500	$218,750	$116,250
ALBUTEROL INHALER	SCHERING	$3.50	$5.95	70%	40000	$140,000	$238,000	$98,000
IPRATROPIUM INHALER	BOERINGER	$13.95	$21.50	54%	14300	$199,485	$307,450	$107,965
CLONIDINE PATCH – 1	BOERINGER	$3.93	$5.98	52%	6000	$23,580	$35,880	$12,300
NADOLOL 40mg (100s)	SQUIBB	$45.00	$60.00	33%	1500	$67,500	$90,000	$22,500
CLONIDINE PATCH – 3	BOERINGER	$9.19	$12.15	32%	10000	$91,900	$121,500	$29,600
CLONIDINE PATCH – 2	BOERINGER	$6.63	$8.75	32%	8000	$53,040	$70,000	$16,960
CAPTOPRIL 50mg (1000s)	BRISTOL MYERS	$610.00	$750.00	23%	580	$353,800	$435,000	$81,200
CAPTOPRIL 25mg (1000s)	BRISTOL MYERS	$370.00	$450.00	22%	200	$74,000	$90,000	$16,000
SUCRALFATE 1gm (100s)	MARION	$44.00	$50.00	14%	5250	$231,000	$262,500	$31,500
RANITIDINE 150mg (100s)	GLAXO	$81.00	$91.00	12%	6600	$534,600	$600,600	$66,000
DILTIAZEM 90mg SR (100s)	MARION	$56.00	$62.00	11%	1750	$98,000	$108,500	$10,500
NAPROSYN 250mg (500s)	SYNTEX	$260.00	$285.00	10%	500	$130,000	$142,500	$12,500
DILTIAZEM 120mg SR (100s)	MARION	$73.00	$80.00	10%	1650	$120,450	$132,000	$11,550
NAPROSYN 375mg (500s)	SYNTEX	$330.00	$360.00	9%	310	$102,300	$111,600	$9,300
NAPROSYN 500mg (500s)	SYNTEX	$405.00	$435.00	7%	310	$125,550	$134,850	$9,300
LOVASTATIN 20mg (60s)	MERCK	$82.80	$88.20	7%	2500	$207,000	$220,500	$13,500
		TOTAL COST				$2,690,455	$3,529,380	
		INCREASE IN TOTAL COST 1990–1991 ($)						$838,925
		INCREASE IN TOTAL COST 1990–1991 (%)						31.18%

Source: Study by NYU Wagner School of Public Service

TABLE 3: HARBORVIEW MEDICAL CENTER (Seattle, WA) PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 1990–1991	1990 Units Purchased	TOTAL COST 1990	TOTAL COST 1991	COST INCREASE 1990–1991
NORINYL 1+35 (28s)	SYNTEX	$0.01	$16.00	159900%	864	$9	$13,824	$13,815
NORINYL 1+50 TAB (28s)	SYNTEX	$0.01	$16.00	159900%	144	$1	$2,304	$2,303
WARFARIN 10mg (100s)	DUPONT	$1.00	$63.00	6200%	8	$18	$504	$486
WARFARIN 7.5mg (100s)	DUPONT	$1.00	$61.00	6000%	12	$18	$732	$714
OXYCODONE/APAP TAB (100s)	DUPONT	$1.00	$46.00	4500%	998	$998	$45,908	$44,910
WARFARIN 5mg TAB (100s)	DUPONT	$1.00	$41.00	4000%	107	$158	$4,387	$4,229
WARFARIN 2.5mg (100s)	DUPONT	$1.00	$40.00	3900%	92	$92	$3,680	$3,588
WARFARIN 2mg (100s)	DUPONT	$1.00	$39.00	3800%	32	$32	$1,248	$1,216
WARFARIN 1mg (100s)	DUPONT	$1.00	$37.00	3600%	10	$10	$370	$360
METAPROTERENOL INHALER	BOERINGER	$3.00	$5.00	67%	2628	$7,884	$13,140	$5,256
CARBAMAZEPINE 200mg (1000s)	GEIGY	$79.00	$120.00	52%	384	$30,336	$46,080	$15,744
PHENYTOIN 100mg CAP (1000s)	PARKE DAVIS	$85.00	$115.00	35%	451	$38,335	$51,865	$13,530
DIVALPROEX 250mg TAB (100s)	ABBOTT	$31.00	$40.00	29%	827	$25,637	$33,080	$7,443
CIMETIDINE 300mg TAB (100s)	SKF	$49.00	$62.00	27%	239	$11,711	$14,818	$3,107
DIVALPROEX 500mg TAB (100s)	ABBOTT	$58.00	$73.00	26%	600	$34,800	$43,800	$9,000
ETHOSUXIMIDE 250mg CAP (100s)	PARKE DAVIS	$35.00	$44.00	26%	94	$3,290	$4,136	$846
CIMETIDINE 400mg TAB (60s)	SKF	$50.00	$62.00	24%	387	$19,350	$23,994	$4,644
IPRATROPIUM INHALER	BOERINGER	$14.00	$17.00	21%	4356	$60,984	$74,052	$13,068
		TOTAL COST				$233,663	$377,922	
		INCREASE IN TOTAL COST 1990–1991 ($)						$144,259
		INCREASE IN TOTAL COST 1990–1991 (%)						61.74%

Source: Study by NYU Wagner School of Public Service

TABLE 4: HENNEPIN COUNTY MEDICAL CENTER (Minneapolis, MN) PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 1990–1991	1990 Units Purchased	TOTAL COST 1990	TOTAL COST 1991	COST INCREASE 1990–1991
WARFARIN 5mg TAB (100s)	DUPONT	$15.67	$349.55	2131%	88	$1,379	$30,760	$29,381
FLUPHENAZINE 10mg (1000s)	PRINCETON	$92.95	$986.10	961%	11	$1,022	$10,847	$9,825
FLUPHENAZINE 5mg (100s)	PRINCETON	$8.45	$83.10	883%	87	$735	$7,230	$6,495
THIOTHIXENE 10mg (1000s)	WARNER CHILCOTT	$148.81	$642.14	332%	15	$2,232	$9,632	$7,400
THIOTHIXENE 20mg (500s)	WARNER CHILCOTT	$153.47	$452.35	195%	17	$2,609	$7,690	$5,081
PHENYTOIN 100mg CAP (1000s)	PARKE DAVIS	$41.38	$103.22	149%	323	$13,366	$33,340	$19,974
CONJ. ESTROGEN 1.25mg (1000s)	WYETHE–AYERST	$107.43	$257.16	139%	12	$1,289	$3,086	$1,797
ALBUTEROL INHALER	SCHERING	$6.00	$11.28	88%	13625	$81,750	$153,690	$71,940
NEBCIN 1.2gm	LILLY	$385.94	$551.21	43%	50	$19,297	$27,561	$8,264
CLONIDINE PATCH –3	BOERINGER	$34.16	$48.16	41%	426	$14,552	$20,525	$5,973
ATROVENT INHALER	BOEHRINGER	$12.76	$17.45	37%	1260	$16,078	$21,987	$5,909
IMURAN Inj 20 ml	BURROUGHS WELLCOME	$48.43	$62.37	29%	356	$17,241	$22,204	$4,963
PROVENTIL sol 3ml (25s)	SCHERING	$20.04	$25.01	25%	1801	$36,092	$45,043	$8,951
CEFTIN 500mg (60s)	GLAXO	$177.63	$221.67	25%	105	$18,651	$23,275	$4,624
SELDANE 60mg (100s)	MARION	$55.10	$66.24	20%	1124	$61,932	$74,454	$12,521
RANITIDINE 150mg (100s)	GLAXO	$66.67	$98.68	14%	196	$16,987	$19,341	$2,354
RANITIDINE 150mg (60s)	GLAXO	$51.25	$58.30	14%	5304	$271,830	$309,223	$37,393
RANITIDINE 300mg (30s)	GLAXO	$46.99	$53.30	13%	948	$44,547	$50,528	$5,982
PIROXICAM 20 mg (500s)	PFIZER	$775.36	$871.12	12%	48	$37,217	$41,814	$4,598
SULCRAFATE 1gm (100s)	MERRELL DOW	$44.80	$50.20	12%	832	$37,274	$41,766	$4,493
CALCIJEX 1mcg/ml (50s)	ABBOTT	$336.50	$370.30	10%	397	$133,591	$147,009	$13,419
ROCALTROL 0.25mcg (100s)	ROCHE	$72.52	$79.41	10%	382	$27,703	$30,335	$2,632
DILTIAZEM 60mg SR (100s)	MARION	$42.73	$46.67	9%	655	$27,988	$30,569	$2,581
NAPROSYN 500mg (500s)	SYNTEX	$395.93	$432.26	9%	92	$36,426	$39,770	$3,344
TENORMIN 100mg (100s)	ICI	$85.56	$93.26	9%	388	$33,197	$36,193	$2,995
PROZAC 20mg (100s)	DISTA	$141.10	$153.80	9%	823	$116,125	$126,577	$10,452
IMURAN 50mg (100s)	BURROUGHS WELLCOME	$73.36	$79.96	9%	2326	$170,635	$185,987	$15,352
			TOTAL COST			$1,241,746	$1,550,436	
			INCREASE IN TOTAL COST 1990–1991 ($)					$308,690
			INCREASE IN TOTAL COST 1990–1991 (%)					24.86%

Source: Study by NYU Wagner School of Public Service

TABLE 5: REGIONAL MEDICAL CENTER AT MEMPHIS (Memphis, TN)
PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 1990–1991	1990 Units Purchased	TOTAL COST 1990	TOTAL COST 1991	COST INCREASE 1990–1991
"A" 100mg CAP (1000s)	"U"	$78.74	$112.96	43%	184	$14,486	$20,785	$6,298
"B" 1mg (100s)	"V"	$29.66	$38.97	31%	2	$59	$78	$19
"C"	"W"	$14.12	$17.52	24%	610	$8,613	$10,687	$2,074
"D" 500mg TAB (100s)	"X"	$62.21	$73.40	18%	19	$995	$1,176	$180
"D" 250mg TAB (100s)	"X"	$33.73	$39.84	18%	36	$1,214	$1,434	$220
"E" 50mg (1000s)	"Y"	$606.62	$821.60	16%	23	$16,022	$16,697	$2,676
"B" 10mg (100s)	"V"	$37.04	$66.09	16%	30	$1,711	$1,983	$271
"E" 25mg (1000s)	"Y"	$417.95	$479.28	15%	44	$18,390	$21,088	$2,698
"F" 60mg SR	"Z"	$56.68	$64.92	15%	58	$3,287	$3,765	$478
"F" 90mg SR	"Z"	$73.68	$84.61	15%	40	$2,955	$3,384	$429
"B" 2.5mg (100s)	"V"	$36.84	$41.95	14%	58	$2,125	$2,433	$308
"B" 5mg TAB (100s)	"V"	$37.14	$42.51	14%	141	$5,237	$5,994	$757
"B" 7.5mg (100s)	"V"	$56.07	$64.16	14%	67	$3,757	$4,299	$542
TOTAL COST						$78,855	$96,003	
INCREASE IN TOTAL COST 1990–1991 ($)								$17,148
INCREASE IN TOTAL COST 1990–1991 (%)								21.75%

Note: Pharmaceuticals and manufacturers deidentified at hospital's request.
Source: Study by NYU Wagner School of Public Service

TABLE 6: PARKLAND MEMORIAL HOSPITAL (Dallas, TX) PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 1990–1991	1990 Units Purchased	TOTAL COST 1990	TOTAL COST 1991	COST INCREASE 1990–1991
WARFARIN 10mg (100)	DUPONT	$2.60	$62.70	2312%	208	$541	$13,042	$12,501
WARFARIN 2mg (100)	DUPONT	$1.60	$38.50	2306%	192	$307	$7,392	$7,085
WARFARIN 2.5mg (100)	DUPONT	$1.70	$39.80	2241%	280	$476	$11,144	$10,668
WARFARIN 5mg TAB (100)	DUPONT	$1.80	$38.40	2033%	3400	$6,120	$130,560	$124,440
WARFARIN 7.5mg (100)	DUPONT	$3.30	$60.90	1745%	120	$396	$7,308	$6,912
OTHO-NOVUM 7-7-7	ORTHO	0.11	0.75	582%	13824	$10,368	$10,368	$0
TERCONAZOLE VAGINAL CREAM	ORTHO	$4.95	$9.75	97%	9800	$48,510	$95,550	$47,040
ORTHONOVUM 1+50 (28'S)	ORTHO	1.7	2.75	62%	3456	$9,504	$9,504	$0
PHENYTOIN 100mg CAP (1000)	PARKE DAVIS	$31.00	$49.00	58%	1400	$43,400	$68,600	$25,200
DIVALPROEX 250mg TAB (100) *	ABBOTT	$25.70	$36.48	42%	2500	$64,250	$91,200	$26,950
CAPTOPRIL 50mg(1000)	BRISTOL MYERS	$565.00	$755.00	34%	312	$176,280	$235,560	$59,280
CAPTOPRIL 25mg(1000)	BRISTOL MYERS	$339.00	$453.00	34%	624	$211,536	$282,672	$71,136
CLONIDINE PATCH -3	BOERINGER	$7.91	$9.69	23%	1728	$13,668	$16,744	$3,076
CLONIDINE PATCH -1	BOERINGER	$3.39	$4.15	22%	6912	$23,432	$28,685	$5,253
CLONIDINE PATCH -2	BOERINGER	$5.71	$6.99	22%	6912	$39,468	$48,315	$8,847
NAPROXEN 250mg(500)	SYNTEX	$234.50	$279.50	19%	1248	$292,656	$348,816	$56,160
LOVASTATIN 20mg(60)	MERCK	$75.00	$88.48	18%	1800	$135,000	$159,264	$24,264
NAPROXEN 375mg(500)	SYNTEX	$306.50	$358.00	17%	1872	$573,768	$670,176	$96,408
ENALAPRIL 10mg(100)	MERCK	$57.30	$66.90	17%	2500	$143,250	$167,250	$24,000
		TOTAL COST				$1,792,930	$2,402,150	
		INCREASE IN TOTAL COST 1990–1991 ($)						$609,220
		INCREASE IN TOTAL COST 1990–1991 (%)						33.98%

Source: Study by NYU School of Public Service

TABLE 7: PRICE INCREASES FOR WIDELY USED OUTPATIENT DRUGS

DRUG (Hospital)	Manufacturer	PER UNIT COST 1990	PER UNIT COST 1991	% INCREASE 90–91
ALBUTEROL INHALER (Hennepin)	SCHERING	$6.00	$11.28	88.00%
ALBUTEROL INHALER (Grady)	SCHERING	$3.50	$5.95	70.00%
IPRATROPIUM INHALER (Grady)	BOERINGER	$13.95	$21.50	54.12%
PHENYTOIN 100mg CAP (1000s) (Grady)	PARKE DAVIS	$30.00	$90.00	200.00%
PHENYTOIN 100mg CAP (1000s) (Hennepin)	PARKE DAVIS	$41.38	$103.22	149.44%
PHENYTOIN 100mg CAP (1000s) (Parkland)	PARKE DAVIS	$31.00	$49.00	58.06%
PHENYTOIN 100mg CAP (1000s) (Harborview)	PARKE DAVIS	$85.00	$115.00	35.29%
WARFARIN 5mg TAB (100s) (Harborview)	DUPONT	$1.00	$41.00	4000.00%
WARFARIN 5mg TAB (100s) (Hennepin)	DUPONT	$15.67	$349.95	2133.25%
WARFARIN 5mg TAB (100s) (Parkland)	DUPONT	$1.80	$38.40	2033.33%
WARFARIN 5mg TAB (100s) (Grady)	DUPONT	$2.00	$35.00	1650.00%
RANITIDINE 150mg (60s) (Hennepin)	GLAXO	$51.25	$58.30	13.76%
RANITIDINE 150mg (100s) (Grady)	GLAXO	$81.00	$91.00	12.35%
RANITIDINE 150mg (100s) (Parkland)	GLAXO	$84.70	$85.30	0.71%
CAPTOPRIL 25mg (1000s) (Parkland)	BRISTOL MYERS	$339.00	$453.00	33.63%
CAPTOPRIL 50mg (1000s) (Parkland)	BRISTOL MYERS	$565.00	$755.00	33.63%
CAPTOPRIL 50mg (1000s) (Grady)	BRISTOL MYERS	$610.00	$750.00	22.95%
CAPTOPRIL 25mg (1000s) (Grady)	BRISTOL MYERS	$370.00	$450.00	21.62%
NAPROXEN 250mg (500s) (Parkland)	SYNTEX	$234.50	$279.50	19.19%
NAPROXEN 375mg (500s) (Parkland)	SYNTEX	$306.50	$358.00	16.80%
NAPROXEN 250mg (500s) (Grady)	SYNTEX	$260.00	$285.00	9.62%
TERCONAZOLE VAGINAL CREAM (Grady)	ORTHO	$4.10	$8.75	113.41%

Grady – Grady Memorial Hospital (Atlanta, GA)
Harborview – Harborview Medical Center (Seattle, WA)
Hennepin – Hennepin County Medical Center (Minneapolis, MN)
Parkland – Parkland Memorial Hospital (Dallas, TX)

Source: Study by NYU Wagner School of Public Service

STATEMENT OF VINCENT MARRONE

Mr. MARRONE. I am Vince Marrone, Deputy Director for Public Affairs for the AIDS Institute, an office of the New York State Department of Health. With me is Lanny Cross who runs our Drug Assistance Program for AIDS patients in New York.

I appreciate the opportunity to be here today on this important topic. I would like to thank Mr. Waxman for his leadership on AIDS, the issue that is so important to me, and what he has done for the people in this country, as well as what your staff has done.

I would like to talk about the price of AIDS drugs and how it relates to problems our program has had in New York. A recent study just released that was done by the Federal Government indicated that 15 percent of the cost of AIDS care was for drugs. Examples of the kinds—and it is increasing. Examples of the kinds of drugs and the prices of drugs that AIDS patients are faced with include pentamidine, which is a prophylactic treatment for PCP. In New York it costs $100 for a vial of pentamidine. That goes for $25 in Europe currently.

Seven or 8 years ago that same drug went for $25 in New York. Foscarnet, which has been in the press lately, goes for $25,000 a year for AIDS patients. Acyclovir has increased use in the treatment of herpes and AIDS patients and has increased approximately 25 percent in the last 2 years.

Obviously, there is some motivation behind these kind of prices. Many in the AIDS communities would characterize the pricing of AIDS drugs as something of a desperation factor which the pharmaceutical companies have included in their calculus, the desperation factor being that the more desperate the disease, the higher the price they think they can charge for these drugs.

The result for our program and for other programs around the State is that the money we have available for the AIDS Drug Assistance Program funded under Ryan White, can only go so far. In New York, for example, over half of our program currently is funded through title I money, which is to say that New York City gives the State, which is required under title II to run the Drug Assistance Program, $8 million. We have a $15 million, to run our program. Without money from title I we would be unable to serve the needs of people in New York State.

A recent survey that the National Association of State and Territorial AIDS Directors just conducted found that in the coming year 22 States are going to reduce coverage in their AIDS Drug Assistance Program because the money they have will not go far enough to cover the needs of the people they are serving. Two States, New Jersey and Georgia are on the verge of eliminating their program because they don't have the money to make it to the end of the year.

There are obviously two solutions to this problem for us. One obviously is to get more money. I would be remiss if I did not come to Washington and say that we need more money for AIDS services, including research and prevention and health care under Ryan White.

Understanding that that is not going to happen, at least not to the degree we need it, the alternative is some regulation of the pricing of AIDS drugs.

To that point we support Mr. Wyden's bill and the rebate formula included in that bill. The reason for that is that the New York program, the AIDS Drug Assistance Program, as well as the programs found in five other States, are run essentially like Medicaid programs. Patients have ID cards. They go to pharmacies. There is a network of 1,300 pharmacies in New York State that serve our clients. We have approximately 7,600 clients in our program.

This system allows ready access to them to any pharmacy in their neighborhood to go in and get their drugs. Essentially, a discount program, therefore, would not work for us. We would require a rebate program in order to realize some benefits under this program. Included in my testimony are the names of the other States, as well as program contacts if you would like to discuss it with them. The second thing would be to add a confidentiality requirement to the legislation to the extent that information is going to be shared with the Federal Government and with institutions, rather drug providers that may have names attached. We feel it is important to insure there are some safeguards to those names so that people with AIDS will not be afraid to come forward and seek the medication they need.

One final point on the voluntary programs that have been promoted by the industry: We would feel that those programs are by definition inadequate. In essence, I think what has happened, and I think the sentiment in the AIDS community is that pharmaceutical companies have raised their prices through the roof and then given up a modest rebate which they expect us to thank them for. We would expect that there be a federally mandated program to insure that the rebate is substantial and fully covers every program that needs it.

If the companies want to do a voluntary rebate on top of that, we would welcome it. I will stop there.

[The prepared statement of Mr. Marrone follows:]

TESTIMONY OF THE

NEW YORK STATE DEPARTMENT OF HEALTH

AIDS INSTITUTE

Good morning. My name is Vincent Marrone, and I am Deputy Policy Director for Government Affairs for the AIDS Institute, an office of the New York State Department of Health. With me is Mr. Lanny Cross, Director of the New York State AIDS Drug Assistance Program, which subsidizes the purchase of 57 drugs for approximately 7,300 New Yorkers with HIV infection and AIDS. We appreciate the opportunity to present testimony to the subcommittee today. Our comments will focus primarily on H.R.3405, the Public Health Clinic Prudent Pharmaceutical Purchasing Act, and a related Senate bill, S.1729 sponsored by Senator Kennedy.

The cost of pharmaceutical drugs is among the leading factors contributing to the rapidly increasing cost of treating people with HIV infection and AIDS. Data released at the International AIDS conference just last week confirms this fact. According to Dr. Fred Hellinger of the Agency for Health Care Policy and Research, the lifetime cost of treating a person with AIDS has nearly doubled in the past 4 years, from $57,000 in 1989 to $102,000 today.

Dr. Hellinger attributes much of this staggering increase to the increased cost of new AIDS therapies. On average, an AIDS patient will spend $4,000 a year on medications, with some patients spending over $10,000 a month. Drug costs make up approximately 15% of the total cost of AIDS treatment, and are expected to rise as new drugs are developed.

This is not to say that the development of new therapies is problematic. The New York State Department of Health, as well as the National Association of State and Territorial AIDS Directors (NASTAD) and the Association of State and Territorial Health Officers (ASTHO) strongly support increased funding for AIDS-related drug research.

What is a problem is the cost of these new drugs. AIDS drug pricing appears in part to be driven by what could be characterized as the Desperation Factor: the more desperate the disease, the higher the drug price.

The earliest manifestation of this pricing policy was AZT, and recent examples indicate that the trend continues. Foscarnet, used in the treatment of retinitis, sells for the staggering sum of $20,000 per year. Acyclovir, sold exclusively by Burroughs Wellcome, has increased in price by 24% in the past 2 years as its use for AIDS-related herpes has become common. And pentamidine, a prophylaxis against PCP (pneumocystis carinii pneumonia), costs $124 per vial in New York City while the same product sells for $25 in Europe. Prior to receiving FDA approval for use as a PCP prophylaxis, pentamidine sold for $25 in the U.S. as well.

While one could debate what factors contribute to the high cost of foscarnet and other drugs used in the treatment of HIV and AIDS, one fact is clear: without some measure to control the costs of these medications, programs established to provide care to persons with AIDS will be bled dry.

And states are also reeling from the high costs of prescription drugs in other health programs. The OBRA 1990 prescription drug amendments helped state Medicaid programs realize much-needed savings by allowing them to access the lowest or "best price" available for prescription drugs. It is imperative that states continue to receive "best price" discounts if they are to continue to provide coverage in the face of skyrocketing prescription drug costs.

While the Medicaid "best price" program has been helpful, it has not relieved the pressure our AIDS drug assistance programs are under. Evidence of this pressure is contained in a recent nationwide survey conducted by the National Association of State and Territorial AIDS Directors. This survey found that 22 states will soon be forced to cut back on their AIDS drug programs, including the states of Florida, Ohio, Washington, Massachusetts, and Illinois. In addition, New Jersey and Georgia will be forced later this year to suspend their programs entirely. (See Attachment 1 for survey results.)

Thus, the cruel irony of AIDS care is that as new, more effective treatments become available, fewer people are able to afford them.

There are at least two solutions to this dilemma. One is to acknowledge that funding is insufficient and call on Congress to increase appropriations to meet the ever-growing need for AIDS drugs. Indeed, I would be remiss if I did not state the desperate need of states for additional funding for services such as the AIDS drug assistance programs funded under Title II of the Ryan White CARE Act, as well as for AIDS prevention services funded by the Centers for Disease Control.

The other solution is to accept as an unfortunate reality that programs established to provide reimbursement for AIDS medications will inevitably be abused by manufacturers who understand only too well that the sky is the limit when it comes to pricing AIDS medications, and to take appropriate mitigating actions. In a context of exorbitant pricing and increasingly unmet need, the need for the relief offered under a federally-mandated rebate program is critical.

The proposed legislation--H.R.3405 and S.1729--will provide reduced drug prices to certain programs funded under the Public Health Service Act. AIDS Drug Assistance Programs funded under Title XXVI are included among the entities eligible for this benefit. In order to understand which bill will best serve AIDS drug assistance programs, it is helpful to briefly review the way New York's program operates.

New York State employs a statewide network of over 1,300 enrolled pharmacies to provide AIDS medications. An ADAP participant presents a pharmacy with their personal enrollment card when ordering a prescription. The pharmacy then files a